



AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
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May 7, 2014

Ms. Susan Spadaro, Administrator
Village At Cedar Hill, Inc
92 Cedar Hill Drive
Windsor, VT 05089-4436

Dear Ms. Spadaro:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 9, 2014**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:jl

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Division of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	MAY - 5 14 Division of Licensing and Protection	(X3) DATE SURVEY COMPLETED C 04/09/2014
NAME OF PROVIDER OR SUPPLIER VILLAGE AT CEDAR HILL, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 92 CEDAR HILL DRIVE WINDSOR, VT 05089			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite re-licensing survey and the investigation of an entity reported incident was completed by the Division of Licensing and Protection from 4/8/14 through 4/9/14 to determine compliance with the Assisted Living Residence regulatory requirements. Regulatory violations were cited related to the entity reported incident.	R100			
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that 1 of 6 residents (Resident #6) in the applicable sample was reassessed at any point in which there was a change in the resident's physical or mental condition. Findings include: 1. Per review on 4/9/14 of documentation provided by the facility, on Saturday, 11/17/12 during the second shift, Resident Assistant (RA) B observed Resident #6 in a state of drowsiness when s/he went to administer 4:00 PM medications. Resident #6 had a physician's order for 0.5 mg of Ativan (an antianxiety medication) scheduled to be given at 4:00 PM. At that time RA B decided to hold the scheduled 4:00 dose of	R136	Resident Care and Home Services 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. The Village at Cedar Hill Nurse Manager, Director of Nursing/RN Oversight and Executive Director initiated the investigation of incident with Resident #6 on 11/19/12. Once Village management completed the investigation, the Nurse Management educated the staff member in question to the critical importance of notifying the Nurse Manager promptly of any change to resident condition to insure the nurse has the opportunity to assess the resident's change in condition in a timely manner. The Village at Cedar Hill created a new policy for Resident Assistants regarding Nurse Notification. All current Resident Attendants that work for the Village at Cedar Hill will be educated on and sign off on this policy by 6/1/14. (See below for Nurse Notification Policy.) The Village also has a new section in its Medication Course detailing when RAs should notify the nurse manager or on call nurse. The Nurse Manager of the Village at Cedar Hill will routinely review resident records to insure that he/she is aware of current resident conditions and these changes in conditions are being documented and staff is notifying nurse management timely.		

Division of Licensing and Protection

~~LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE~~

TITLE

(X6) DATE

~~SHOT~~

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1007

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R136	Continued From page 1 Ativan due to drowsiness. RA B discovered in the Medication Administration Record (MAR) that a day shift staff (RAA) had administered 0.5 mg Ativan "as needed for anxiety" (PRN) at both 11:45 AM and 2:35 PM. The prescribed PRN dose was actually 0.25 mg, per facility documentation. RA B elected at that time to write a note to the Village Director and the nurse, neither calling the nurse on call over the weekend, nor the physician, to report the wrong medication doses and the state of drowsiness for Resident #6. It was therefore not until Monday morning, 11/19/12 that the Director and nurse found the note and summoned the Director of Nursing/Registered Nurse (DNS/RN) to assess Resident #6 at 8:30 AM. Per written documentation of the incident, and during an interview on 4/9/14 at 10:30 AM, the DNS confirmed that RA B failed to notify and consult nursing or the physician at the time of discovering Resident #6 in a state of drowsiness, as per facility policy and expectation.	R136	<p>If a Resident Assistant is found to breach this policy the staff member in question will be educated and progressively disciplined up to and including termination. In addition, Village management will hold a staff meeting with all Resident Assistants to discuss and re-educate.</p> <p>Date of Completion 6/1/2014</p> <p>Village at Cedar Hill Nurse Notification Policy It is the policy of The Village at Cedar Hill that Resident Attendants will notify the Nurse Manager, Director of Nurses or on call nurse promptly in the following situations:</p> <ul style="list-style-type: none"> • Resident Falls • New Resident bruise or skin tear. • Resident is experiencing a new behavior. • Resident wanders without purpose outside the facility • Resident Attendant questions a physician order • Resident Attendant notices a mental or physical change from the resident baseline. • Resident Attendant questions a treatment or other nursing procedure or has any question or concern regarding nursing care or medication management. <p>This notification ensures that a licensed nurse is given the opportunity to assess the resident and notify the primary care physician to consult changes in status and care regimen.</p> <p>The Resident Attendant must write a note to document the situation, the call to the nurse and the nurse's response to the Resident Attendant. The Nurse will also document needed follow through once they are on site.</p>	
R162 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that staff did not assist with or administer any medication for which there is	R162	<p>Resident Care and Home Services</p> <p>5.10 Medication Management</p> <p>5.7c Staff will not assist with or administer any medication, prescription or over- the- counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record.</p> <p>The Village at Cedar Hill Nurse Manager, Director of Nurses and Executive Director initiated investigation into incident with Resident #6 on 11/19/12. The staff member in question was not able to be reached at that time, but did meet with nurse management team on 11/21/12. The staff member in question was terminated from employment at this time based on the conclusion of the investigation. Nurse Management then held a staff meeting with Resident Attendants to re-educate them on this topic.</p>	

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R162	<p>Continued From page 2</p> <p>not a physician's written, signed order in the resident's record, for 1 of 6 residents in the applicable sample (Resident #6). Findings include:</p> <p>1. On 4/9/14 a review of records provided by the facility revealed that Resident Assistant (RA) A administered two wrong doses of Ativan (an antianxiety medication) to Resident #6. Resident #6 had a physician's order for 0.5 mg of Ativan (an antianxiety medication) scheduled to be given at 4:00 PM. An order for Ativan was also available "as needed for anxiety", with the dose written as 0.25 mg every 2 hours. There was not a written physician's order for an as needed (PRN) dose of Ativan at the level of 0.5 mg. Resident Assistant A elected, without physician or nursing consultation, to administer 0.5 mg of Ativan for anxiety at both 11:45 AM and 2:35 PM on 11/17/14. Per written documentation of the incident, and during an interview on 4/9/14 at 10:30 AM, the Director of Nursing Services confirmed that RA B failed to consult the physician or contact the nurse on call before deciding to administer the two doses of Ativan at 0.5 mg rather than as ordered by the physician (0.25 mg).</p>	R162	<p>The Village at Cedar Hill has added to the Medication Administration Policies a specific notation regarding administering medication for ordered medications only and under what conditions Resident Attendants should call the nurse manager on duty. (See Nurse Notification Policy).</p> <p>All Resident Attendants that work for the Village at Cedar Hill will be re-educated on the Medication Administration Policy by 6/1/14. (See below for Medication Administration Policy.) This policy is reviewed as part of the current Village Medication Course and all Resident Attendants must sign off.</p> <p>The Nurse Manager of the Village at Cedar Hill will review all resident MAR at least weekly to confirm medications are being given as the physician ordered.</p> <p>If a Resident Assistant is found to breach this policy the staff member in question will be educated and progressively disciplined up to and including termination. In addition, Village management will hold a staff meeting with all Resident Assistants to discuss and re-educate.</p> <p>To Be Completed By 6/1/14</p> <p>The Village at Cedar Hill</p> <p>Medication Administration Policy and Procedure</p> <p>Purpose: The purpose of this policy and procedures is to guide Medication Certified Staff with proper administration of the resident's medication. All resident's medication will be stored in a locked cabinet in each apartment.</p> <p>Guidelines:</p> <ol style="list-style-type: none"> 1. All medications ordered by the resident's attending physician will be stored in a locked cabinet in that resident's apartment with the exception of narcotics, which are stored in the locked narcotic box of the medication cart. Medications that need to be refrigerated are stored in the med room refrigerator 	

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			<ol style="list-style-type: none"> 2. The controlled medications are counted at the start and end of the shift with both on coming and off going Resident Assistants verifying the pill card and the book are correct. The Resident Assistant that is there for the entire shift will hold the only Narcotic Box key. When a Narcotic is needed both RAs on shift will be present to sign out and verify count. The Resident Assistant giving the medication will be the one signing out in the narcotic book. 3. A Medication Certified Resident Assistant, on duty each work shift, will have the responsibility for the master key to the locked medication cabinets in apartments, for the resident to have their medication administered by facility staff. Residents who are assessed capable of self administration of the medication will have their own key to the cabinets in their apartments. 4. The Village Director, the Director of Nursing Service and the Nurse overseeing the Village will have master keys to all of the cabinets. 5. All medications will be appropriately labeled by the pharmacy. 6. Each resident will have an individual note book with his/her name, and apartment number identifying it. This notebook will also contain each resident's picture, diagnosis sheet and physician's standing orders. The Current MAR will be on the Electronic Medical Record. 7. All medications administered by staff will be documented as administered and refusal of medications will be documented in the eMAR with the reasoning as to why, after 3 refusals in 1 week, the Nurse overseeing the Village is to be notified and will then notify the physician. 8. A current list of Resident Assistants who have completed their medication certification course and who are authorized to administer regularly scheduled and PRN medications at the Village will be kept in the Director's office and the Locked Medication Room. 9. Residents who are receiving psychoactive medications on a PRN basis and any Antipsychotic medication will have a behavioral monitoring record in the MAR to document for any side effects and behaviors. Any residents noted to have side effects at any time will notify the Nurse overseer and Director of Nurses. 10. The delegating RN will observe medication administration for medication certified employees when there is a change in the RN overview. 	

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			<p>11. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis to problem statement in the residents record</p> <p>12. If there is a concern with an order the Nurse Manager will be notified promptly.</p> <p>13. Any concerns about a residents condition needs to be brought to the Nurse promptly (refer to Nurse notification Policy)</p> <p>Date: _____</p> <p>_____ Resident Attendant</p> <p>_____ Nurse Manager or DNS</p>	